Medical Referral Form for Infants and Children

Massachusetts WIC Program

Child's name: _____ **DOB:** _____

Clinician: Please complete this section - WIC eligibility will depend on this information.
Parent authorization appears on the reverse side of this form.

Bloodwork required for children >6 months:

One blood test required	Date taken:
HGB _____ gm or **HCT** _____ %	___ / ___ / ___ ___ / ___ / ___
Lead _____ mg (optional)	___ / ___ / ___

Weight and height must be less than 60 days old on date of WIC appointment.

Current weight _____ lb _____ oz
Current length _____ in
Date ___ / ___ / ___

First visit only:

Birth weight _____ lb _____ oz
Birth length _____ in

Update immunization book or attach copy of record or give dates:

	DTaP	Polio	MMR	Hib	Hep B	VZV	PCV 7
First							
Second						■	
Third			■			■	
Fourth			■		■	■	
Fifth	■	■	■	■	■	■	■

Please note all that apply:

- ☐ Repeated GI disturbances (infant only), mo/yr: ___ / ___
  1. ___ / ___ 2. ___ / ___ 3. ___ / ___
- ☐ Infectious disease, specify: _____
- ☐ Food allergy or intolerance, specify: _____
- ☐ Traumatic injury / burns / surgery, mo/yr: ___ / ___
- ☐ Iron deficiency anemia
- ☐ Lead poisoning
- ☐ Congenital anomaly or developmental delay impairing feeding / utilization of nutrients
- ☐ Failure-to-thrive
- ☐ Chronic ear / upper resp. infections within last year, mo/yr:
  1. ___ / ___ 2. ___ / ___ 3. ___ / ___
- ☐ Mental illness / retardation
- ☐ Mother / caretaker with mental illness / retardation
- ☐ Mother / caretaker with substance abuse, specify: _____
- ☐ Chronic nutrition-related medical condition, specify: _____
- ☐ Other, specify: _____

_____
signature of clinician

_____ ___ / ___ / ___
clinician's name (please print) date

_____ – _____ – _____
phone

_____ – _____ – _____
fax

_____
health center / hospital

_____
street

_____ _____
city zip

Send completed form to:

Medical Referral Form for Infants and Children
Massachusetts WIC Program

Parent/Guardian Authorization: Please complete this section.

Child's name _____ (Print Name)

Your name _____ (Print Name)

Street _____ Apt. _____

City _____ Zip _____

Phone ____ – ____ – ____

Child's date of birth ___ / ___ / ___ Sex ☐M ☐F

Child on WIC before? ☐Yes ☐No

Language spoken _____

I, _____ (Print Name) give permission to _____ (Doctor, Nurse, Healthcare Provider) to release to WIC information on the MRF, which appears on the other side of this form, for determining the nutritional risk of my child for WIC eligibility.

- I understand that I do not have to give my doctor, nurse, or healthcare provider permission to share information about my child with WIC. If I choose not to give this permission, to receive WIC benefits I will need to give permission directly to WIC to obtain my child's length/height, weight, and bloodwork at the WIC office.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to my provider and send it or bring it where I am now giving permission:

_____
(address of Doctor, Nurse, Healthcare Provider)

If the information has already been given out, I understand that it is too late for me to change my mind and cancel the permission.

Authorized Signature: _____

Relationship to Participant: _____

Date: ___ / ___ / ___

This authorization is valid for 60 days after the date the health information (height/weight) is obtained.

WIC staff are required to follow federal law to protect WIC participant confidentiality and cannot re-disclose WIC applicant or participant information except with written consent or as required by law.

(see over)

For WIC use	initials
Date rec'd _____	_____
Appt. _____	_____
WIC # _____	

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